ADULT REGISTRATION

Name _____
last first middle

Address _____

City _____ State _____ Zip _____

Age _____ Birth Date _____ Home Phone _____

Occupation _____

Business Phone _____

Cell Phone _____

MINOR REGISTRATION

Patient's Name _____
last first middle

Parent's Name _____

Address _____

City _____ State _____ Zip _____

Age _____ Birth Date _____ Home Phone _____

Male ☐ Female ☐ School _____ Grade _____

_____ _____
Father's Occupation Mother's Occupation

_____ _____
Father's Cell Phone Mother's Cell Phone

Person(s) Responsible for Acct. _____

Orthodontic Insurance Company _____

Family dentist _____

Date Last Dental Check-up _____

Other Family Members Who Come Here _____ Patient Referred by _____

Has Patient Seen Another Orthodontist? _____ Name: _____

Family Physician _____ General Health _____

Allergies _____ Have You Ever Had an Allergic Reaction to Latex? _____

Under Physician Care? ☐ No ☐ Yes For: _____

Medications Taken/Other Medical Information _____

Do You Have a Heart Murmur Which Requires Antibiotics prior to Dental Appointments? _____

Would you like to receive an e-mail reminder for appointments? _____ E-mail Address _____

Hobbies _____